FORMAL ADOPTION APPLICATION

Use of form: Completion of this form is mandatory under the provisions of HFS 51.06(1) for persons whom the Department has determined meet the screening requirements for an adoptive home or otherwise qualify to submit an adoption application. If the Department receives an incomplete home study application form, the form shall be returned to the inquirer for completion. The Department may close the application process to any person who has been provided with an application form if the form has not been completed and returned within 60 days after the date of mailing. The application date is the date the form is received by the Department with complete information. Your social security number will be used for identification purposes only.

Instructions: Return the completed, signed form to your regional adoption supervisor.

A. APPLICANT(S)							
Husband or Single Male			Wife or Single Female				
Name - (Last, First, Middle)			Maiden Name - (Last, First, Middle)				
Previous names (If applicable)			Previous names (If applicable)				
Birthdate (mm/dd/yyyy)	Birthplace		Birthdate (mm/dd/yyyy) Birth		olace		
Social Security Number	Religion		Social Security Number	Religion			
Hispanic / Latino	ICWA Apply	?	Hispanic / Latino ICWA Ap		ply?		
☐ Yes ☐ No	☐ Yes ☐	No	☐ Yes ☐ No	☐ Yes	□ No		
Race (Circle up to 5) A = Asian W = White B = Black or African American P = Native Hawaiian or Pacific Islander I = American Indian or Alaska Native			Race (Circle up to 5) A = Asian W = White B = Black or African American P = Native Hawaiian or Pacific Islander I = American Indian or Alaska Native Education - Indicate year completed.				
	cation - Indicate year completed. <u>Brade School</u> <u>High School</u> <u>Post High School</u>			High School	Post High School		
Address - Home (Street, City, State, Zip Code)			1	County			
Township or Village (If applicable)			Telephone Number - Home (Include area code)				
Directions for reaching reside	ence						
Length of time residing at above address			Length of time residing i	n Wisconsin			
B. EMPLOYMENT							
Husband or Single Male				e or Single Fema			
Occupation		Work Hours	Occupation		Work Hours		
Name - Employer Date Started		Name - Employer		Date Started			
Address - Work Telephone - Work		Address - Work		Telephone - Work			
Last Previous Employer Position		Last Previous Employer Position					
If SELF-EMPLOYED, business name and nature			If SELF-EMPLOYED, business name and nature				
☐ Individually owned ☐ Jointly owned ☐ Jointly owned		☐ Individually owned ☐ Date Established (mm/dd/yyyy)					

C. MARRIAGE					Wife or Single Female						
Husband or Single Male Date - Present Marriage - If applicable (mm/dd/yyyy)				Wife or Single Female Date - Present Marriage - If applicable (mm/dd/yyyy)							
Place of Marriage			Place of Marriage								
Previous Marriage(s)			Specify	Previous I	Marriage(s)	Yes	☐ No	If "Yes"	, Specify.		
1 TOVIOUS	lvarrage(3)			No If "Yes", Specify.			Viamage(3)		Ended		, орсспу.
Date	Place of Marr	iage		Ended by Divorce Death Date						Death	Date
									2		24.0
D. HEA	LTH						•				
	Husba	and or Si	ngle Male					r Single	Female		
Name - P	hysician					Name - Pl	nysician				
Address - Physician			Address - Physician								
General F	lealth - Check or	ne.				General Health - Check one.					
☐ Excelle		☐ Fai	ir 🗆 F	Poor		Excellent Good Fair Poor					
	oblem(s) in your f					Health problem(s) in your family history?					
☐ Yes		s", - Spec				Yes No If "Yes", - Specify.					
		о, орос	ош у .					, 0,000			
F 01111	DDEN IN VOLE	LIONE									
E. CHIL	DREN IN YOUR	RHOME				۸۵۵	Gender	Dala	tionahin	Cna	sial Naada
						Age			ationship	'	cial Needs
						In Years	M = Male	B = B			Emotional
			F = Female		dopted oster Child		Behavioral Physical				
Name - (Last, First, MI)				0 = 0			,				

	HOM VOLLE					
Nome (Lost First MI)	F. OTHER PERSONS IN YOUR HOME FOR WHOM YOU PROVIDE DAILY CARE					
Name - (Last, First, MI)	Age	Relations	ship		Care Need	
G. OTHERS RESIDING IN YOUR HOME						
Name - (Last, First, MI)			Age	F	Relationship	
H. BACKGROUND						
Answers to the following questions alone will not	necessarily d	lisqualify you fro	m being cons	sidered as a	doptive parents.	
	ng or drug pro		tional problem			
Name - Family Member	Date(s) of Treatment	Name - Treatment Provider			
·						
Has either of you ever been convicted of violating a language.	aw other than	a minor traffic vi	olation?			
Yes No If "Yes", - Specify.	aw other than					
	aw other than		olation? City, State		Conviction Date	
Yes No If "Yes", - Specify.	aw other than				Conviction Date	
Yes No If "Yes", - Specify.	aw other than				Conviction Date	
Yes No If "Yes", - Specify.	aw other than				Conviction Date	
Yes No If "Yes", - Specify.	aw other than				Conviction Date	
Yes No If "Yes", - Specify.	aw other than				Conviction Date	
Yes No If "Yes", - Specify.	aw other than				Conviction Date	

County(s) and municipality(s) in which each adult caretaker in the home has lived or worked in the last 5 years - Specify. Residence Employment Name - Caretaker City / State Name - Employer City / State County County

DEPARTMENT OF HEALTH AND FAMILY SERVICES

Division of Children and Family Services CFS-136 (Rev. 05/2001)

I. FINANCIAL STATEMENT	Γ						
Annual Income			<u>Liabilities</u>				
Gross income - husband \$		<u> </u>	Mortgage balance - current \$				
Gross income - wife \$		_	Loans, notes, liabilities - total amount due	\$			
Gross income - total annual \$		\$	Other debts or liabilities - List.				
Net income after taxes - annual		\$		\$			
Assets				\$			
Home value - current		\$		\$			
Savings account(s) - total		\$		\$			
Stocks and bonds - total		\$	Retirement				
Life insurance - husband or sin	gle male		Are you under a retirement plan?	☐ Yes ☐ No			
Name -			Insurance - Medical				
			Do you have family medical insura	ance? 🗌 Yes 🗌 No			
Face value of policy		\$	If "Yes", - Specify.				
Life insurance - wife or single fe	emale		Company Name				
Name - Company							
			Insurance - Homeowner's or F	Renter's			
Face value of policy		\$	Do you have homeowner's or renter's ☐ Yes ☐ No				
Other assets - List.		insurance? If "Yes", - Specify.					
		\$					
		\$	Company Name				
		Ψ	Policy Number				
-		\$					
		\$					
Monthly Expenditures							
Rent or mortgage payments	\$		Medical and dental	\$			
Heat and utilities	\$		Household expenses	\$			
Groceries	\$		Education expenses	\$			
Recreation and entertainment	\$		Other major expenses - List.				
Transportation	\$			\$			
Installment purchases	\$			\$			
Savings	\$			\$			
Clothing	\$			\$			
Voluntary contributions	Voluntary contributions \$			\$			
Insurance premiums \$				\$			

J. REFERENCES						
You may be asked to consider signing a release of information form regarding our contacting the references you provide.						
List names of three persons who know	you well and are not related to you.					
Name Address - Street, City, State, Zip Code Telephone						
K. AUTHORIZATIONS						
In making our (my) application to the Division of Children and Family Services for placement of a child, we (I) understand						
	there is not a commitment by the agency that a child will be placed in our (my) home. The agency is free to consult with the persons or entities named herein. We (I) understand that the Department will not limit their inquiries to those persons					
	serves the right to request the consent of the a					
•	community / personal references. The statements in this application are, to the best of our (my) knowledge and true belief,					
correct and complete. Knowingly providing false information on this application form can result in the Department closing the						
adoption application under HFS 51.07(3).						
SIGNATURE - Wife or Single Female Date Signed						
GIGITATIONE WING OF ORIGINAL		3				
SIGNATURE - Husband or Single Male Date Signed		Date Signed				